STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING 00 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN 46805

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 13, 14, 15, 16, and 19, 2012. Facility number: 000092 Provider number: 155176 AIM number: 100266090 Survey team: Diane Nilson, RN- TC Angela Strass, RN Sue Brooker, RD Rick Blain, RN Census bed type: SNF/NF: 74 Total: 74 Census payor type: Medicare: 12 Medicaid: 54 Other: 8 Total: 74 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on November 20, 2012 by Bev Faulkner, RN	F0000	Glenbrook Rehabilitation and Skilled Nursing Center is requesting a desk review of the submitted plan of correction. We have attached documents supporting the identified CQI tools, trainings, and audits to be utilized in correcting the cited items. If you have further questions please contact Gregg Fuller Executive Director. We thank you for your consideration in this matter	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure nursing staff knocked on resident doors and waited for a response prior to entering the resident's room. This potentially affected 2 residents (#26 and #97) of 13 residents who resided on the 300 hall. Finding Includes: On 11/16/12 at 8:20 a.m., Nurse #1 prepared Resident #26's medications. The nurse went through the open door of the resident's room saying "Knock. Knock." On 11/16/12 at 11:40 a.m., Nurse #1 entered Resident #97's room to give her insulin. Nurse #1 did not knock on the resident's door, she called the resident by name and walked in without waiting for the resident to give permission.	F0241	F 241 Dignity and Respect of Individualit It is the practice of this provider to promote care for all residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. DNS interviewed Resident #26 and #53 affected by the deficient practice. Both Resident #26 and #53 did not report a loss of dignity or respect by Nurse #1. Nurse #1 and Nurse #2 have been re-educated to knock on resident door and wait for a response prior to entering residents' rooms. Other residents on the same hallway were interviewed and report that staff knocks on their doors and waits for a response prior to entering their rooms. All staff in serviced on 12/4/12 by DNS and designees in regards to knocking on residents' doors and waiting for a response prior to entering. All staff in serviced on 12/4/12 to knock on doors and wait for response prior to entering resident's room. DNS and designees will monitor the resident rooms daily to ensure	11/30/2012

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	Observation on 11/16/12 at 3:00 p.m., Nurse #2, entered Resident #26's room to do a wound treatment. The nurse was observed to walk half way into the room, back out of the room and then call the resident's name and then knock on the door. The nurse then walked into the room without waiting for the resident to respond. On 11/19/12 at 2:30 p.m., review of the "Facility Orientation for Employees" information indicated "Remember to knock on the resident's door before entering-remember, you are in the resident's home." Interview with the Director of Nursing on 11/19/12 at 2:34 p.m., indicated staff are to knock and wait to enter resident rooms. 3.1-3(t)		that staff are knocking on doors and waiting for response prior to entering resident's rooms. DNS and designees will monitor, using the dignity and privacy CQI form for compliance daily for 2 weeks, then weekly for 2 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination. Systemic changes will be completed by 12/4/12.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure a care plan to address impaired vision was developed for 1 of 18 residents who met the criteria for vision (Resident #41). Findings include: The record for Resident #41 was reviewed on 11/19/12 at 9:00 A.M. A Minimum Data Set Assessment (MDS), dated 9/17/12, indicated Resident #41's vision was impaired.	F0279	F279 Develop Comprehensive Care Plans: It is the practice of this facility to use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.Social Services developed a care plan for impaired vision for Resident #41 to include resident's refusal to wear glasses dated 11/19/2012. All residents who have impaired vision have the potential to be affected by the same deficient practice. Social Services to review all residents with impaired vision to ensure that a care plan	12/02/2012

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	The Care Area Assessment (CAA) Summary, dated 9/17/12, indicated "Resident chooses not to wear glasses and had difficulty reading newsprint during interview of 9/17/12. He is able to propel wheelchair safely in halls. Needs large print for written materials." The CAA indicated a care plan was to be developed to address the resident's impaired vision. A review of Resident #41's record did not indicate a care plan to address impaired vision had been developed. The facility's Social Services Director (SSD) was interviewed on 11/19/12 at 1:15 P.M. During the interview, the SSD indicated she performed the vision screenings for the MDS assessments and was responsible for developing care plans for impaired vision if indicated. The SSD reviewed Resident #41's care plans and was unable to provide a care plan addressing impaired vision. During the interview, the SSD indicated a care plan for Resident #41's impaired vision should have been developed, but a care plan to address the resident's impaired vision had not been developed. A facility policy entitled "Care Plan Review and Maintenance Process,		is in place. All new admissions to the facility are assessed for vision needs by a licensed nurse on the nursing assessment. SS will be in-serviced by the ED or designee to ensure care plans will be completed when the resident is identified to have vision impairment. Social Services and/or designee will utilize the Vision CQI form weekly for 4 weeks, monthly for 3 months, and then quarterly for 6 months thereafter to monitor for compliance. Results will be forwarded to the CQI committee monthly for review. An additional action plan will be developed for any findings below the threshold of 90%. MDS and/or designee will use the care plan updating CQI form weekly for 4 weeks, then monthly for 3 months, and then quarterly for 6 months thereafter to monitor for compliance. Results will be forwarded to the CQI committee monthly for review. An additional action plan will be developed for any findings below the threshold of 90%. Non-compliance may result in disciplinary action up to and including termination. Systemic changes will be completed by 12/2/12.	

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	dated 8/2011, indicated "It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessment." 3.1-35(a)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to	F0441	F441 Infection Control, Prevent Spread, Linens	12/04/2012

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	ensure staff washed hands before and after wearing exam gloves during 1 of 1 observations of medication administration through a gastrostomy tube (G-tube) affecting 1 resident (Resident #80). Findings include: On 11/16/12 at 11:55 A.M., LPN #3 was observed in the hallway at the medication cart preparing medications to be administered to Resident #80 through a G-tube (feeding tube). The LPN was not observed to wash her hands or to use hand sanitizer prior to preparing the medications. The LPN was observed to enter Resident #80's room to administer the medications. The LPN was observed to put on disposable exam gloves and administer the medications through the g-tube . The LPN was not observed to wash her hands or to use hand sanitizer prior to putting on the exam gloves. The LPN completed the administration of the medications and removed the exam gloves and disposed of them in a waste basket. The LPN then left the room and returned to the medication cart and documented the administration of the medications on the computer. The LPN was not observed to wash her hands or to use		It is the practice of this facility to establish and maintain an Infection Control Program designed to a provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. LPN #3 was re-educated on G-tube care per policy and a skills validation for G-tube medication administration was completed. Resident #80 is receiving g-tube care with appropriate infection control procedures. All residents who receive medications via a G-tube have the potential to be affected by the alleged deficient practice. All nurses will complete a G-tube medication administration skills validation check-off with infection control guidelines by DNS and/or designee by 12/4/12. An all staff in-service will be held on 12/4/12 for infection control and gloving by DNS and/or designee. All nurses to complete a G-tube medication administration skills validation check-off with infection control guidelines by 12/4/12 and an all staff in-service on 12/4/12 for infection control and gloving by DNS and/or designee.All new nursing staff will complete G-tube medication administration and gloving skills validations upon hire and quarterly thereafter by DNS and/or designee. DNS /designee will conduct rounds on all shifts to	

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	hand sanitizer after removing the exam gloves and returning to the medication cart. The Facility Director of Nursing (DON) was interviewed on 11/19/12 at 1:50 P.M. During the interview, the DON indicated staff were to wash hands before putting on exam gloves and after removing exam gloves when providing resident care. On 11/19/12 at 2:30 P.M., the facility Assistant Director of Nursing (ADON) indicated the facility hand washing policy did not address glove usage and hand washing. The ADON provided a Skills Validation checklist entitled "Gloves", dated 3/2012, and indicated the checklist was considered to be the facility's policy. The checklist indicated staff were to wash hands prior to putting on exam gloves and after removing the gloves. 3.1-18(l)		ensure appropriate infection control procedures are followed for g-tube care. DNS and/or designee will utilize the Infection Control CQI weekly x 4 weeks, then monthly thereafter for at least 6 months. Results to be forwarded to CQI monthly for review. An additional action plan will be developed for a threshold below 90%. Non-compliance may result in disciplinary action up to and including termination. Systemic changes to be completed by 12/4/12.	